UPDATES
In School Health
SCHOOL HEALTH UNIT
Winter 2004

PREVENTING AND RESPONDING TO VIOLENCE: THE EVER-PRESENT CHALLENGE FOR SCHOOLS

Studies suggest that between 3.3 to 10 million children witness intimate partner violence annually in the United States. The Massachusetts Department of Education (MDOE) estimates that 14% of high school females and 5% of high school males have already experienced sexual contact against their will (MDOE, 2001 YRBS). Each week an average of one young person (ages 10 to 24) completes suicide in Massachusetts, and one in four students has seriously considered suicide in the past year. Many Massachusetts students experience violence or the psychological and physical effects of previous violence, sometimes on a daily basis. This raises serious questions for the school: How do these experiences affect the student's ability to learn? What role can and should the school play in preventing violence meanwhile responding to those who already have been affected by it?

We know that there are several types of supports crucial to children who are traumatized by violence: nurturing relationships with supportive adults; predictability and a sense of routine; safe space to talk about their experiences; reminders that they are important, good people that others care about; developmentally appropriate skills and tools for nonviolent behavior; and models of nonviolent and respectful problem-solving. Schools can play a key role in providing these keys to success for children.

School health professionals, as well as other staff, need to be alert to the child or adolescent who may be the victim of violence. This means providing a safe atmosphere for concentration and learning, as well as a secure, trusting relationship for those who are ready to share their trauma, sadness and concerns. It means offering patience and kindness to those who have not yet reached the point of sharing. And it means providing resources for referral when the student is seeking help.

Creating a climate that promotes respect for others, tolerates and rejoices in differences, emphasizes equality, and simultaneously provides the tools for both students and staff to learn and practice positive behaviors is a major challenge. It requires the commitment of administrators, staff, students and parents. It requires a strong focus on prevention with curricula beginning at the earliest grades that are both age appropriate and consistent with the child's developmental needs. It requires opportunities to practice skills in managing differences of opinion in a safe environment, thus preparing the student for life outside the educational system.

Sound policy development and implementation are other tools to address this issue. The Massachusetts Department of Education, as well as many other agencies, have model policies on a variety of issues including, but not limited to dating violence, safe schools for gay, lesbian, bisexual, transgender (GLBT) youth, and a safe physical environment for students.

Does your school cultivate a positive atmosphere for students, as well as faculty? We challenge you to spend ten minutes observing your school's climate—during change of classes, lunchtime and any other period when many students and staff may gather. Are students courteous to each other? How do students and faculty interact? Is harassment or bullying tolerated? In short, does your school promote respect for others?

Carlene Pavlos, MTS
Director, Division of Violence & Injury Prevention

Anne Sheetz, RN, MPH
Director of School Health Services

When children are treated with respect, they conclude that they deserve respect and hence develop self-respect. When children are treated with acceptance, they develop self acceptance; when they are cherished, they conclude that they deserve to be loved, and they develop self esteem.

Stephanie Martson, The Magic of Encouragement, 1990

NEWSBRIEFS

UPDATE OF THE SCHOOL HEALTH SERVICE WEBSITE:

The School Health Unit has been updating its website to include information on statutes and regulations, infectious diseases, HIPAA issues, etc. Please bookmark this site: http://www.state.ma.us/dph/fch/schoolhealth/index.htm

CHANGE IN NAME:

The name for the Massachusetts Department of Public Health-funded Enhanced School Health Service Programs has been changed to "Essential School Health Service Programs". The goals of these community-based programs are consistent with those of the 10 Essential Public Health Services established by CDC and others: See: http://www.apha.org/ppp/science/ESposter.htm

MASSACHUSETTS ASTHMA ACTION PLANS (MAAP):

The tri-part Massachusetts Asthma Action Plans are available through the Massachusetts Health Promotion Clearinghouse. Plans are available in English, Spanish, Portuguese, Haitian Creole, Chinese, Vietnamese, Khmer, and Russian. They may be viewed and/or ordered online through www.maclearinghouse.com or by sending a FAX order form to (617) 536-8012. School nurses are encouraged to request that parents give the MAAP to the child's primary care provider for completion. (The Massachusetts Health Promotion Clearinghouse consumer information line is 1-800-952-6637.)

ASTHMA SURVEILLANCE:

A special thank you to all school nurses who participated in the asthma surveillance program (K through grade 8) conducted jointly by the Bureau of Environmental Health Assessment and the School Health Unit, Bureau of Family and Community Health. Despite the funding reductions, 72% of the schools in the Essential School Health Service Programs responded. The Department plans to send letters regarding the asthma rate to each participating school district. The plan is to extend the surveillance to all schools (K through 8) this spring.

REPORTING EPI-PEN®, ADMINISTRATION IN THE SCHOOLS:

The Massachusetts Department of Public Health has revised the regulations for administration of epinephrine to students experiencing a life-threatening allergic reaction in the schools to include before and after school programs. (See School Health Service website.)

The new regulations require that a report be sent to the School Health Unit, MDPH whenever Epi-Pen®, is administered. The form is available on the School Health Service Website: http://www.state.ma.us/dph/fch/schoolhealth/medadmin.htm, or, from the School Health Unit. This is part of the School Health Service quality improvement program. Between 9/01/03 and 12/31/03, the Department had received 47 reports of Epi-Pen®, administration. Two students were not transported to a medical facility via Emergency Medical Services (EMS) following the administration of epinephrine. ***Please note: because of the possibility of a biphasic reaction, all persons receiving an Epi-Pen® for a life-threatening allergic event must be transported to the local emergency medical facility.*** There continue to be a number of children experiencing anaphylaxis with no previous history of an allergic reaction (23%). Please be sure that the parents of these children have adequate medical follow-up and instruction on the use of the Epi-Pen®.

BIOTERRORISM AND EMERGENCY PREPAREDNESS:

As the Commonwealth and its communities plan for a possible bioterrorism event, schools may play an important role. School nurses and physicians are encouraged to become part of this planning process. Please call your local Board of Health for further information.

TRAINING PROGRAM ON PREVENTION OF BLOODBORNE DISEASES FOR SCHOOL PERSONNEL:

The Massachusetts Division of Occupational Safety (DOS) has developed two PowerPoint presentations to assist in the training of public school personnel on the prevention of bloodborne diseases: (a) "Bloodborne Diseases: Prevention of Transmission for School Staff" is geared to those staff members who would be "reasonably anticipated" to be exposed to blood based on the nature of their jobs, and (b) "Prevention of Transmission for School Staff Not Directly Responsible for Providing Care or Cleaning Up Blood." These PowerPoint presentations are available on disk, free of charge, by either: (a) calling the Occupational Health / Indoor Air Quality Program at (617) 969-7177; (b) faxing your request to (617) 727-4581; or (c) mailing your request to: Massachusetts Division of Occupational Safety, Occupational Health / Indoor Air Quality Program, 1001 Watertown Street, West Newton, MA 02465. Please include your name, title, school, mailing address, and phone number.

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Children Exposed To Domestic Violence

Kris Lyons, M.S.W, L.I.C.S.W. and Jean MacDonald, MDPH

Growing up in a home with intimate partner violence (often called domestic violence) can be a terrifying and traumatic experience. Witnessing or experiencing violence can affect all aspects of a child's life from growth and development to becoming more likely to suffer or commit violent crimes late on if life. It is likely to affect children's schooling and makes them more likely to face a host of health problems that can last throughout their lifetime (Groves, Augustyn, Lee & Sawires, 2002). Studies suggest that between 3.3 to 10 million children witness intimate partner violence annually (Carlson as cited in Family Violence Prevention Fund, 2003).

The most obvious and dangerous risk for children who live in homes in which there is intimate partner violence is that they become direct victims of the abuse. In 30 to 60 percent of families affected by intimate partner violence, children are also directly abused (Edleson as cited in Groves, Augustyn, Lee & Sawires, 2002). Young children and adolescents are more vulnerable to abuse. Very young children cannot get out of harms' way. Adolescents more frequently intervene to stop the violence, thereby putting themselves at greater risk for injury even when they do not become direct targets of abuse. Children who are exposed to intimate partner violence, particularly chronic episodes of violence, often show symptoms associated with post-traumatic stress disorder. One study found that exposure to intimate partner violence (without directly being victimized) was sufficiently traumatic to precipitate moderate to severe symptoms of posttraumatic stress in 85 percent of the children (Kilpatrick, Litt & Williams as cited in Groves, Augustyn, Lee & Sawires, 2002).

RESPONSES

Not all children are affected by exposure to intimate partner violence in the same way. Children's reactions to trauma vary. Some children may appear to be more resilient while others may be deeply affected. Factors such as age, gender, proximity to the violence and the frequency and severity of the violence affects children's responses. There are also outside factors that affect a child's response to the trauma such as the response of the caregiver, other characteristics of the family, and interventions of community agencies (Groves, Augustyn, Lee & Sawires, 2002).

There are a number of health effects and behaviors that have been associated with children who live in homes where intimate partner violence is occurring. Children in the youngest age ranges, from birth to 4 years, can experience premature birth, delayed development, sleep disorders, separation problems, physical injury, and overall anxiety. Children from 5-12 years old, often exhibit symptoms ranging from bedwetting and separation anxiety, to increased aggression and injury, to problems in school associated with socialization, inability to concentrate, and problems with rules or authority. As children age, there may be gender stratification in responses to domestic violence with the development of harmful attitudes toward women, gender-proscribed parentification and tolerance of controlling or even violent behavior in dating relationships (Waldman, 2001; Groves, 1999; Endabuse.org, 2003; Fantuzzo & Mohr, 1999; Culross, 1999).

TREATMENT AND INTERVENTION

Experts agree that the most important intervention with a child can be to support their relationship with the non-abusive caregiver. Battered parents ought not to be held responsible for the negative effects of violence on their children- that is the sole responsibility of the abusive partner. Rather, victims of violence may need information about sources of support and assistance as well as messages from school personnel that the violence is wrong and not their fault.

In addition to work with the non-abusive parent, group counseling is the most widely described intervention for children who witness domestic violence (Strauss and Gelles as cited in Groves, 1999). Group treatment can assist children and adolescents with important developmental tasks. Group treatment can break the isolation and enable children to safely tell their stories in the presence of others who closely identify with their experiences (Wright, Wright & Issac as cited in Groves, 1999).

Most group counseling runs between 6 to 10 weeks and uses a specific psycho- educational curriculum that provides structure for discussions about family violence, personal safety, and identification of feelings (Carlson as cited in Groves, 1999). Group counseling can be found in some battered women's shelters, mental health clinics, or social service agencies. Group treatment usually targets children between the ages of 6 and 15, typically grouping children in age spans of two to three years (Carlson as cited in Groves, 1999). For younger children it is usually recommended to have individual intervention with strong parent counseling components. Also, groups may not be appropriate or recommended for children who have been severely traumatized, because these children may have more complex needs and would be better served by individual treatment (Groves, 1999).

The Department of Social Services funds Child Witness to Violence Programs across the state. To obtain a listing of these programs, please contact Kris Lyons at 617 624-5466 or Kristin.Lyons@state.ma.us.

Effective and Ineffective Strategies to Reduce Youth Violence

Lindsay Rosenfeld, Harvard School of Public Health, Masters of Science Candidate, MDPH Intern, Summer 2003

The World Health Organization (WHO) determines violence by young people to be "one of the most visible forms of violence." (World Health Organization, Youth Violence Fact Sheet, 2002) The WHO estimates that in 2000, 199,000 youth murders took place globally – equivalent to 565 children and young people age 10-29 years dying on average each day as a result of interpersonal violence. (World Health Organization, Youth Violence Fact Sheet, 2002) The WHO recognizes three levels of risk factors as contributors to youth violence: individual factors; influences by family and peers; and social, political and cultural factors.

In a 2002 document entitled *What You Need To Know About Youth Violence Prevention,* the U.S. Department of Health and Human Services describes various effective and ineffective strategies for youth violence prevention. Programs from which the following strategies were drawn are measured to be effective or ineffective based on their design, the significance of their deterrent effects on violence or serious delinquency, the effect of replication, and the effects of sustainability.

At the *primary prevention level,* interventions for the general population of young people, the report suggested that effective strategies include:

- skills training,
- behavior monitoring and reinforcement,
- building school capacity (to plan, implement, and sustain positive changes),
- continuous progress programs (for student achievement),
- cooperative learning, and
- positive youth development programs.

Yet, ineffective primary prevention strategies were found to include:

- peer counseling,
- peer mediation,
- peer leaders, and
- nonpromotion to succeeding grades.

Note: it is important to remember that "effective" and "ineffective" were determined in relationship to their impact on preventing youth violence and that strategies determined ineffective in this regard may, nonetheless, have other benefits to participants.

At the *secondary prevention level,* interventions for children at high-risk of violence, effective strategies include:

- parent training (to use specific child-management skills),
- home visitation,
- compensatory education (to improve academic performance),
- moral reasoning,
- social problem solving, and
- thinking skills.

Yet, ineffective strategies for secondary prevention strategies were found to include:

- gun buyback programs,
- firearm training,
- mandatory gun ownership,
- redirecting youth behavior, and
- shifting peer group norms.

At the *tertiary prevention level,* interventions for violent or seriously delinquent youth, effective strategies include:

- social perspective taking, role taking,
- multimodal interventions,
- behavioral interventions,
- skills training,
- marital and family therapy by clinical staff, and
- wraparound (social) services.

Yet, ineffective strategies for tertiary prevention strategies were found to include:

- boot camps,
- residential programs,
- milieu treatment,
- behavioral token programs,
- waivers to adult court,
- social casework, and
- individual counseling.

The Youth Risk Behavior Survey, Massachusetts 2001, demonstrates that this knowledge about effective and ineffective strategies on the primary, secondary, and tertiary intervention levels must be incorporated into design measures.

- In Massachusetts, one in eight students (13%) carried a weapon such as a gun, knife, or club in the 30 days before the survey.
- Six percent carried a weapon on school property in the 30 days before the survey.
- One third (33%) of all Massachusetts students were in a physical fight in the 12 months before the survey – roughly 10% of those who fought were injured.
- Just under 12% of all students were in a physical fight on school property in the 12 months before the survey.
- In Massachusetts, 8% of students skipped school at least once in the 30 days before the survey because they felt unsafe either at school or on their way to or from school.
- Violence-related behaviors occurred equally in urban, suburban, and rural communities in Massachusetts.
- 29% of all students reported feeling so sad or hopeless that they stopped doing some usual activities for a period of two weeks or more in the 12 months before the survey.

Implementation of these effective strategies has been shown

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Effective and Ineffective Strategies to Reduce Youth Violence *continued from page 4*

to reduce these types of youth violence experiences exhibited throughout Massachusetts.

Visit the following websites for more information on other youth violence issues, programs, and strategies:

- Youth Violence: A Report of the Surgeon General
  http://www.surgeongeneral.gov/library/youthviolence/
- Best Practices of Youth Violence Prevention
  http://www.cdc.gov/ncipc/dvp/bestpractices.htm
- "What You Need To Know About Youth Violence Prevention"
  http://www.mentalhealth.org/publications/allpubs/SVP-0054/default.asp
- "World Report on Violence and Health," WHO (World Health Organization)
  http://www.who.int/violence_injury_prevention/violence/world_report/wrvh1/en/
- Youth Violence Fact Sheet, WHO (World Health Organization)
  http://www.who.int/violence_injury_prevention/media/en/560.pdf

Teen Dating Violence

Adapted by Marci Diamond, MPA, Director, Sexual Assault Prevention and Survivor Services Program, MDPH, from a 1997 *News In School Health* article written by Carole Souza

Violence in teen dating relationships is a problem faced by many schools. The 2001 Youth Risk Behavior Survey conducted by the Department of Education in high schools across Massachusetts found that 16% of girls and 6% of boys had experienced violence in a dating relationship. Compared to their peers who had not experienced violence, students who had ever experienced any dating violence or unwanted sexual contact were significantly more likely to report feeling sad or hopeless, attempting suicide, skipping school because they felt unsafe, and engaging in binge drinking.

A survey published by the MA Department of Probation in April 1994 stated: "More than 57% of restraining orders issued against teenagers in Massachusetts are concerning a dating relationship. The majority, 87% of teenage batterers involved in dating violence are male. The location where physical abuse is most frequently reported is in the schools. 84% of teenage dating violence occurring at school involves some type of physical violence."

Teen dating violence mirrors adult domestic violence- it is based on controlling behaviors ranging from verbal and emotional abuse, physical assault, to murder and rape. Dating violence affects people from all socio-economic, racial, and ethnic groups, and among heterosexual, gay, and lesbian relationships. Like adult domestic violence, abusive teen dating relationships are often characterized by:

- repeated violence that escalates
- violence that increases in severity the longer the relationship continues
- violence and abusive behaviors interchanged with apologies and promises to change
- an increased danger from the victim at the time of trying to terminate the relationship

However, teen dating violence happens within the context of adolescent development; therefore, certain developmental aspects characteristic of adolescence may be affected. Typically a teen victim is isolated from her/his peers because of the controlling behavior of her/his partner. The following developmental tasks may be interrupted because of this isolation:

- achieving new and mature relationships with peers of both sexes
- social role achievement
- emotional independence
- the ability to develop personal values and beliefs

In addition, the effects of the abuse may hinder teens' academic progress.

Because teens lack experience with intimate relationships, those in abusive relationships often have difficulty in defining abuse as problematic. Incidents of the adolescent victim using physical violence toward her/his partners may occur with more frequency than between adult victims toward adult perpetrators. Young people may perceive possessive jealousy and controlling behavior as loving devotion.

Teens may be reluctant to seek help from adults. They may fear, rightly or wrongly, that if they tell someone about the abuse, they will be seen as having done something wrong. They may also fear that newly gained privileges of independence will be taken away.

In order to promote a safe school environment free of dating violence, a comprehensive school response is necessary. To assist schools in developing comprehensive responses to the issue of teen dating violence, the Department of Education developed *D.O.E. GUIDELINES FOR SCHOOL DISTRICTS ON ADDRESSING TEEN DATING VIOLENCE* which offer a number of recommendations. Understanding the laws is an important first step to

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Responding to PERPETRATORS OF Teen Dating and Domestic Violence in Massachusetts

Nikki Paratore, PhD, Director, Batterer Intervention Program Services, MDPH

Teen dating and domestic violence occur in Massachusetts and nationwide at alarming rates. Consider the following:

- 18% females in grades 9-12 reported being hurt physically or sexually by a date with the rate increasing to 21% among female 12th grade students (1999 Massachusetts Youth Risk Behavior Survey).
- 1 in 5 girls is sexually and/or physically abused by a boyfriend (Silverman et al, 2001).
- Women between the ages of 16 and 24 are nearly three times more vulnerable to intimate partner violence (excluding intimate partner homicide) than women in other age groups (2001 Bureau of Justice Statistics).
- 50% of young men participating in teen dating/domestic violence intervention programs between September, 2000 and March, 2002 reported that their primary victim was a female family member (MA Department of Public Health).

While many are eager to provide assistance and support to victims of teen dating and domestic violence, communities struggle in bringing themselves to similarly address youthful perpetrators of dating and domestic violence. Reasons for this struggle are varied and unique to each community, and include: reluctance to acknowledge that young men in the community are using violent and abusive behavior; legal and social implications for identifying youthful perpetrators; and little funding to provide meaningful intervention services. In spite of these obstacles, many communities throughout the Commonwealth have taken up the challenge to end teen dating and domestic violence by implementing education-based adolescent intervention programs that focus on trying to change the belief systems and behaviors of adolescent perpetrators.

CURRENT ADOLESCENT INTERVENTION SERVICES IN MASSACHUSETTS

The Department of Public Health currently funds 5 certified batterer intervention programs to provide intervention services to adolescent male perpetrators of dating and domestic violence. Among the first of their kind in the nation, these young men's groups are currently operating in Attleboro, Boston, Brockton, Cambridge, Chelsea, Newton, North Attleboro, Norwood, Quincy, and Taunton. The services are provided in accordance with the *Massachusetts Pilot Program Specifications for Adolescent Male Perpetrators of Dating/Domestic Violence.* Adolescent intervention programs primarily receive referrals from schools, juvenile probation, and the Department of Youth Services, although family members, friends, and private therapists also make referrals. All services are provided free of charge. The adolescent intervention program is a 12 hour program which typically meets once per week for 1-2 hours per meeting. The young men's groups are conducted on school grounds, in juvenile court buildings, and in the offices of the batterer intervention programs.

PHILOSOPHY OF ADOLESCENT INTERVENTION PROGRAMS

In order to understand the curriculum of adolescent intervention programs, it is important to grasp the definition of dating and domestic violence that forms the core principle of the programs. In the young men's groups, dating and domestic violence are approached as a pattern of learned behaviors that the young men use in order to establish and maintain control over a female victim. These behaviors include, but are not limited to, physical assault, verbal and emotional forms of assault/control, economic forms of control, sexual assault or coercion, social isolation, stalking, harassment, or ongoing monitoring. The good news is that, because these behaviors are learned, they can be unlearned. An important first step toward changing abusive and controlling behavior is to acknowledge and take responsibility for the behavior. Because they implicate the victim in the circle of responsibility, other forms of intervention such as couples counseling, peer mediation, conflict resolution, and anger management are inappropriate for adolescent perpetrators of dating and domestic violence. Worse still, these types of programs can actually further endanger victims by implicitly conveying the message that victims are to some degree to blame for the perpetrator's violence. It is precisely these types of justifications and beliefs that the young men's groups encourage their participants to see and change in order to live a violence-free lifestyle.

WHO IS APPROPRIATE TO ATTEND AN ADOLESCENT INTERVENTION PROGRAM?

Adolescent intervention programs serve young men between 11 and 18 years old who have 209A domestic violence

Sample Program Curriculum

What counts as violence?
What does it mean to be a man?
Negative vs. positive self talk
Effects of violence
Quick fixes vs. long term solutions
Mental/emotional abuse
Sexual abuse and respect
Identifying verbal abuse
Respectful communication
Being in control of your anger

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Responding to PERPETRATORS OF Teen Dating and Domestic Violence in Massachusetts

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restraining orders against them and/or have used a pattern of controlling behaviors or perpetrated an act of violence or abuse on a dating partner and/or female victim (e.g., mother, female teacher, etc.). Because adolescents tend to define "dating" in fluid ways, the young men's groups similarly define dating as including any relationship which has or has ever had any romantic or sexual aspects. Still further, the groups work with youth who have used violence or abusive behavior against someone with whom a dating relationship was desired by the young man, but did not, in fact, exist. Though participants in the young men's groups range in age from 12 to 18 years old, the average age for participants statewide is 15 years old.

CONCLUSION

The problem of teen dating and domestic violence is complex and will only be solved when everyone in our communities works together. We must mobilize our prevention efforts to teach our young men and women about healthy and respectful relationships. At the same time, we must support all victims of dating/domestic violence in their efforts to be safe. Finally, we must work with young men to help them embrace the skills and value systems that will serve as the foundation for a non-violent lifestyle.

To learn more about adolescent intervention programs or to explore the possibility of implementing an adolescent intervention program in your community, contact Nikki Paratore, PhD, Director, Batterer Intervention Program Services, 617-624-5497, nikki.paratore@state.ma.us or visit http://www.state.ma.us/dph/fch/bi/index.htm

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building a comprehensive response. Other components of this response should include:

- developing a written school policy
- training for the school community to increase awareness
- establishing school based counseling, intervention services and resources
- fostering a school climate that has zero tolerance for dating violence

The complete guidelines can be downloaded from www.doe.mass.edu/hssss/tdv/toc.html. A booklet on this topic developed with and for teens can be downloaded from www.doe.mass.edu/hssss/tdv/brochure.pdf. Limited hard copies of the guidelines and booklets as well as teen dating violence awareness posters, notepads and public service announcements can be requested from the Department of Public Health by contacting Mark Bergeron-Naper at mark.bergeron-naper@state.ma.us or 617-624-5465 (while supplies last).

Local domestic violence programs and rape crisis centers can be invaluable community resources in developing policies, programs, and referrals systems to support safety for all school students and staff. For information on how to contact a local program visit www.janedoe.org.

If you or someone you know needs immediate help or support, contact the statewide dating and domestic violence hotline, **SafeLink, at 877-785-2020.**

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REPEAL OF LAW REQUIRING PRE-EMPLOYMENT TUBERCULOSIS SCREENING OF SCHOOL PERSONNEL AND VOLUNTEERS:

Massachusetts General Law, Chapter 71, Section 55B was repealed on July 31, 2003. The decision to seek legislative action for repeal of this law was based upon recommendations from the federal Centers for Disease Control and Prevention (CDC) to eliminate screening activities in low-risk populations and reserve priority resources for targeted testing and treatment of populations identified as high risk for acquiring tuberculosis.

UNIVERSITY OF MASSACHUSETTS/SIMMONS COLLEGE SCHOOL HEALTH INSTITUTE (SHI):

The School Health Institute will present an abbreviated series of programs in FY 2004. Brochures have been distributed to the schools. Information is available on the website http://www.umass.edu/umsshi/.

REVISED WAIVER FOR CERTAIN SCREENINGS (CHAPTER 71, SECTION 57):

The School Health Unit has revised the waiver application and will require that all schools with existing waivers re-apply in the spring of 2004 for the FY05 school year. The new application may be found at http://www.state.ma.us/dph/fch/schoolhealth/lawsregs.htm.

YOUTH RISK BEHAVIOR SURVEY:

To view results from the 2001 Massachusetts Youth Risk Behavior Survey Report, go to www.doe.mass.edu/hssss/program/youthrisk.html.

The Sexual Assault Nurse Examiner (SANE) Program

Ginhee Sohn, and Shelley Schribman, SANE Program, MDPH

The Sexual Assault Nurse Examiner (SANE) Program is an initiative with the primary goal of improving the care for victims of sexual assault in Massachusetts through the development of a statewide, standardized method of evidence collection and the provision of high-quality, coordinated care within hospital emergency departments. The SANE program also improves the successful prosecution rate of sex offenders through the quality of the evidence that is collected and testimony given by the nurse examiners at trial. The Program is administered by the Massachusetts Department of Public Health (DPH).

The mission of the SANE Program is the delivery of time-sensitive, compassionate, coordinated care to victims of sexual assault by registered nurses and physicians who have been trained, certified, and credentialed through the MA Department of Public Health. The SANEs are available to designated sites in the Commonwealth to care for sexual assault victims aged 12 and over who enter designated emergency departments within 5 days or 120 hours of being assaulted. The SANE cares exclusively for the sexual assault victim providing coordinated services within the emergency department with hospital personnel, law enforcement, rape crisis centers, and social services. The SANE is then available to provide testimony in the prosecution of the sexual assault case. Based on preliminary data collected from analysis of the sexual assault evidence collection kit, 28% of victims receiving exams and evidence collection were between the ages of 12 and 17.

The Massachusetts Pediatric SANE Program is currently in development to provide compassionate, coordinated, comprehensive and child-centered medical care for children 12 years and younger reporting sexual abuse or assault. SANE nurses will conduct developmentally appropriate physical examinations and time sensitive forensic evidence collection in designated settings. Guided by the overriding principle of "do no harm", the Pediatric SANE Program will minimize further stress to the child and family by insuring that Pediatric SANE nurses are responsive to a child's developmental, physical, emotional and cultural needs. Pediatric SANE nurses will also be trained, certified and credentialed through the MA Department of Public Health.

Optimal recovery of the child following sexual assault and abuse often depends on the ability of the non-offending parents/guardians to support their child. To this end the Pediatric SANE nurse will assist with crisis intervention for the child and family and facilitate appropriate referrals for mental health counseling, victim advocacy, and other social services.

For a list of DPH SANE staff and designated hospitals across the Commonwealth, see www.state.ma.us/dph/fch/ violence/ sanelist.htm. For more information on the SANE program, please contact Ginhee Sohn at 617-624-5432 or Ginhee.sohn@state.ma.us.

Drug-Facilitated Sexual Assault

Marci Diamond, M.P.A., MDPH

For a number of years, the MA Department of Public Health in collaboration with many state and community partners has been addressing the serious public health problem and crime of drug-facilitated sexual assaults in Massachusetts. Since 1998, Department staff and the local rape crisis centers we partner with have provided prevention materials and presentations to schools and other interested parties. Current materials can be downloaded from www.state.ma.us/dph/fch/sapss/daterape-drug.doc .

In addition, the Department's Sexual Assault Prevention and Survivor Services (SAPSS) and Sexual Assault Nurse Examiner (SANE) Programs worked with the Executive Office of Public Safety (EOPS) to develop new protocols for voluntary toxicology testing as an optional component of the Massachusetts Sexual Assault Evidence Collection Kits. These kits are distributed to participating hospitals by EOPS to collect forensic evidence within 5 days of a sexual assault. Toxicology testing is only conducted with these kits when indicated and consented to, and only within 3 days of an assault. Survivors who have recently been assaulted may wish to visit a SANE site for an exam by a specially trained clinician supervised by the Department of Public Health. (See article on the SANE program above.)

Survivors who have a toxicology test done as part of the evidence collection kit and have reported the assault to the police can generally obtain their toxicology results about 6 weeks post-test from the Victim-Witness Advocate at the District Attorney's Office handling their case.

Survivors who have had the toxicology test done as part of the kit and have not yet reported to the police can get their toxicology results by contacting a confidential results line 6 weeks after the kit is done. This new telephone service, 1-866-269-4265, is designated exclusively for victims of non-reported assaults who had a toxicology test completed as part of their forensic exams. Any other support needs can be directed to a local rape crisis center www.state.ma.us/dph/fch/sapss/sites.

Update on Massachusetts Rape Crisis Centers

Marci Diamond, M.P.A., MDPH

Rape in the U.S. has been referred to as "a tragedy of youth." (Kilpatrick, D.G., & Ruggiero, K.J., 2003) While people of all ages are sexually assaulted, school-age children and adolescents appear to be at particular risk. The Department of Education estimates that 14% of high-school age females and 5% of high-school age males have already experienced sexual contact against their will (DOE, 2001 YRBS). Among over 25,000 assaults reported to Massachusetts rape crisis centers over a 10 year period, the median age at the time of assault for rape and attempted rape was 20 years for females and 17 years for males. For other forms of physical sexual assault, which can be just as traumatic, the median age was 14 years for females and 10 years for males (MDPH, 1999). Many studies have confirmed the correlation between sexual assault experiences and substantial increases in risk for health problems such as suicide attempts, substance abuse, adolescent pregnancy, eating disorders and even heart disease (Filletti, 2001).

To reduce the incidence and long-term negative effects of sexual assault, the Massachusetts Department of Public Health has been partnering with local rape crisis centers to provide quality sexual assault prevention and survivor services since the early 1980s. In FY02 alone, these centers responded to over 13,000 crisis hotline calls, conducted 8,330 individual counseling sessions and 1,349 group counseling sessions and supported hundreds of survivors during medical exams, court proceedings and police reporting.

Budget cuts at the beginning of FY04 required substantial reductions in services formerly provided to survivors by the rape crisis centers. In addition, several centers were forced to close specific service sites.

However, as of the printing of this newsletter, all rape crisis centers in Massachusetts continue to provide 24 hour confidential counseling, support, information and referral hotlines for: adolescent survivors of all forms of sexual assault; non-offending family/guardians of sexual assault survivors; and adult survivors of sexual assault. Limited, free individual sexual assault crisis counseling is also provided. In addition, schools and community groups can arrange for federally-funded Rape Prevention Education consultation, prevention education workshops and professional training through these centers.

Five centers receive specific federal Rape Prevention Education funding to further enhance their youth sexual assault prevention work and provide leadership in this area. These programs are: Womansplace Crisis Center at Health Care of Southeast MA (Plymouth County/South Shore); Boston Area Rape Crisis Center (Greater Boston/128); Everywoman's Center at the University of Massachusetts (Hampshire County); Elizabeth Freeman Center (Berkshire County); and the YWCA of Lawrence (Greater Lawrence). Complete contact information is available at http://www.state.ma.us/dph/fch/sapss/sites.htm.

Please contact your local rape crisis center (http://www.state.ma.us/dph/fch/sapss/sites.htm), visit www.state.ma.us/dph/fch/sapss, or contact the DPH Program Director Marci Diamond at 617-624-5457 (voice) / 617-624-5992 (TTY) / marci.diamond@state.ma.us (email) for more information.

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Sally Fogerty, Assistant Commissioner

School Health Website: http://www.mass.gov/dph/fch/schoolhealth
Essential School Health Services Website: Website:http://www.mass.gov/dph/fch/schoolhealth/eshs

Supportive and Healthy Comunities For Gay and Lesbian youth (SHCGLY)

Christopher Ferguson, J.D., MDPH

SHCGLY is the Commonwealth's suicide and violence prevention program for gay and lesbian youth. According to the Massachusetts's Youth Risk Behavior Survey, gay, lesbian, and bisexual youth are 4 times more likely to have attempted suicide in the past year, over twice more likely to miss school in the past month because of feeling unsafe, and over twice as likely to have been injured or threatened with a weapon at school than are their heterosexual counterparts. All of these are significant public health concerns.

Working with the Governor's Commission on Gay and Lesbian Youth, the Massachusetts's Department of Public Health supports education and outreach efforts to reduce the incidence of suicide among and violence toward gay, lesbian, bisexual, and transgender (GLBT) youth. The program provides funding for community based agencies and works in collaboration with the Massachusetts's Department of Education's Safe School Program for Gay and Lesbian Students.

The Goals of the Program are:

- to reduce suicide among and violence against GLBT youth; and
- to change social norms in schools and communities in order to create supportive and healthy environments for GLBT youth.

The program goals are achieved through the following objectives;

- to develop and provide state-wide resources for GLBT youth through social/support networks;
- to help all DPH providers who work with youth to better meet the needs of their GLBT clients;
- to provide schools and community-based organizations with the resources to meet the needs of GLBT youth; and
- to increase awareness about GLBT youth issues, particularly among adult gatekeepers who work with young people.

The Program Components include:

- The Gay, Lesbian, Bisexual, and Transgender Youth Group Network of Massachusetts: Directly supports GLBT youth across the state through 17 community-based social/support groups. Provides effective suicide and violence prevention services, peer networking, and social support in an environment free of drugs, alcohol, peer pressure, sexual activity, sexual harassment, and violence.
- The Gay and Lesbian Youth Support Project (GLYS): A comprehensive training program for health and human service providers and other youth-serving professionals around issues concerning GLBT youth.
- Safe Schools Support: Working in collaboration with the Massachusetts Department of Education, the Massachusetts Department of Public Health provides the resources to support school-based gay/straight alliances, faculty and staff trainings, and technical assistance around issues concerning GLBT youth in schools.
- Youth of Color Initiative: An ongoing commitment and effort to make all of the program components inclusive of and more relevant to GLBT youth of color.

For more information, please contact: Supportive & Healthy Communities for Gay & Lesbian Youth, MDPH, 250 Washington Street, Fourth Floor, Boston, MA 02108-5075, (617) 624-5430 (Voice), (617) 624-5075 (FAX), or christopher.ferguson@state.ma.us

Nation's First Suicide Prevention Center Is Housed at EDC In Newton, MA

The nation's first federally funded suicide prevention center is up and running at the Education Development Center (EDC) in Newton, Massachusetts. The National Suicide Prevention Resource Center (SPRC) was created to gather and disseminate evidence-based suicide prevention practices and enhance capacity for state and local suicide prevention planning, implementation and evaluation. The Center provides technical assistance, training, and informational materials through a call center, website, and regional conferences.

Contact SPRC in the following ways:

- Phone: 1-877-GET-SPRC (438-7772)
- TTY: 617-964-5448
- Visit: www.sprc.org
- E-mail: info@sprc.org
- Write: Suicide Prevention Resource Center
  Education Development Center, Inc.
  55 Chapel Street, Newton, Massachusetts 02458-1060.

Youth Suicide Prevention

Ramya Sundararaman, MD, MPH, Senior Technical Assistance Specialist, Suicide Prevention Resource Center

Each week an average of 1 young person between the ages of 10 and 24 completes suicide in Massachusetts.[1] In addition, one in four students (24%) seriously considered suicide in the past year, and one in ten (10%) made an actual suicide attempt.[2]

While these statistics are alarming, suicides are preventable and people who come in contact with these young people can play a significant role in identifying and helping those at risk. The following are some suicide prevention strategies and recommendations[3]:

School gatekeeper training helps school staff (such as teachers, counselors, and coaches) identify and refer students who may be at risk of suicide. Gatekeeper training also teaches staff how to respond to suicide or other crises in the school.

Community gatekeeper training teaches community members (such as clergy, police, merchants, and recreation program staff) and clinical healthcare providers who see adolescent and young adult patients (such as doctors and nurses) to identify and refer persons in this age group who are at risk for suicide.

General suicide education teaches adolescents about suicide, its warning signs, and how to seek help for themselves or others. These programs often incorporate activities that increase self-esteem and social competency.

Screening programs use questionnaires or other screening instruments to identify high-risk adolescents and young adults for additional assessment and treatment. Repeated assessments can be used to measure changes in attitudes or behaviors over time, test the effectiveness of prevention efforts, and to detect potential suicidal behaviors.

Peer support programs are designed to foster peer relationships and competency in social skills among high-risk adolescents and young adults.

Crisis centers and hotlines provide telephone counseling and other services for suicidal persons. Some programs offer "drop-in" crisis centers and referral to mental health services.

Restriction of access to lethal means are strategies that restrict access to handguns, drugs, and other common means of suicide.

Postvention (intervention after a suicide) programs target friends, family, and classmates of persons who completed suicide. They are designed to prevent or contain suicide clusters and to help adolescents and young adults cope effectively with the feelings of loss that follow the sudden death or suicide of a peer.

The following are some recommendations if you would like to start a suicide prevention program in your school or community:

Link suicide prevention programs with professional mental health resources. Strategies designed to increase referrals of at-risk adolescents and young adults can be successful only to the extent that counselors are available and mechanisms for linking at-risk persons with resources are in place.

Avoid reliance on one prevention strategy. As there is limited knowledge regarding the effectiveness of suicide prevention strategies, suicide prevention programs should use several strategies. The following are some promising, but underused, strategies in existing programs:

- Restricting access to lethal means may be the most promising underused suicide prevention strategy. Parents should be taught to recognize the warning signs of suicide and encouraged to restrict their teenagers' access to the means of suicide (such as poisons).
- Peer support groups for adolescents and young adults who have exhibited suicidal behaviors or who have thought and/or attempted suicide also appear promising, but they should be implemented carefully.
- Establishing working relationships with other prevention programs, such as alcohol- and drug-abuse treatment programs, may enhance suicide prevention efforts.
- School staff choosing school curriculum should consider implementing curricula that address suicide prevention in conjunction with other adolescent health issues rather than curricula that address only suicide.

Target adolescents AND young adults. Many prevention programs target high school- age adolescents. But the suicide rate for young adults between the ages of 18-24 is substantially higher than that for adolescents. More prevention efforts should be targeted toward this age group.

Evaluate suicide prevention programs. Planning, process, and outcome evaluation are important components of any public health effort. Evaluations are imperative given the lack of knowledge regarding the effectiveness of suicide prevention programs. Outcome evaluation should include measures such as incidence of suicidal behavior or measures closely associated with such incidence (e.g., measures of suicidal ideation, clinical depression, and alcohol abuse). Program directors should be aware that suicide prevention efforts may have unforeseen negative consequences. Evaluation measures should be designed to detect such consequences

Massachusetts Suicide Prevention Resource Guide: The MDPH has published this guide which can be accessed online:
www.state.ma.us/dph/fch/violence/suicideprevguide.pdf (pdf)
www.state.ma.us/dph/fch/violence/suicideprevguide.doc (word format)

[1] Wisqars, Centers for Disease Control and Prevention
[2] Massachusetts Youth Risk Behavior Survey
[3] Programs for the Prevention of Suicide Among Adolescents and Young Adults, Morbidity and Mortality Weekly Report, April 22, 1994 / 43(RR-6);1-7
[4] Stone, Deb, The Basics of Suicide Prevention, National Center for Suicide Prevention Training

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